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February 12, 2008

Speaker Salvatore F. DiMasi, Massachusetts House of Representatives
President Therese Murray, Massachusetts Senate
Chairwoman Patricia A. Walrath, Joint Committee on Health Care Financing
Chairman Richard T. Moore, Joint Committee on Health Care Financing
Chairman Robert A. DeLeo, House Committee on Ways and Means
Chairman Steven C. Panagiotakos, Senate Committee on Ways and Means

Dear Senators and Representatives:

Pursuant to section 132 of Chapter 58 of the Acts of 2006, I am pleased to provide the General Court with the latest 60-day report of the Patrick Administration's progress in implementing Chapter 58. As with every update, the last two months have brought significant advancement in the implementation of Chapter 58 as we continue to meet the deadlines for implementing various provisions of the law and continue to enroll people in health insurance at historic rates.

Over the past two months the Administration has focused on regulatory processes to make the final stages of implementation as seamless as possible. In February 2008, as discussed in section 3, the Department of Revenue issued draft guidelines for Individual Mandate Penalties for the 2008 tax year, which will range from zero to \$912 for qualifying adults who forego coverage for the entire year. To protect consumers from unnecessary penalties, the Division of Insurance issued requirements for insurance providers to disclose whether health policies meet minimum creditable coverage standards, as discussed in section 6.

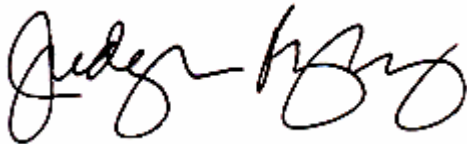
The last two months are also notable for successful outreach among communities and businesses. In November 2007, as discussed in section 1, MassHealth awarded \$3.5 million in outreach grants to forty-five community based-organizations. Within the first month of operation, these organizations reported assisting 6,700 people with the application process, and over 6,500 individual have been approved for benefits. In

January, DOR has also launched a video tutorial for completing the Schedule HC, the new tax form that individuals must complete to show proof of coverage, to be used by individuals and advocacy organizations in preparation of the new 2007 tax filing requirements.

Looking ahead to the next 60 day period, we in the Patrick Administration will focus on finalizing regulations and community outreach. To ensure the individual mandate is applied fairly across the Commonwealth, the Connector Authority, in close conjunction with the DOR, is in the final planning stages for the full-scale implementation of an appeals process, as discussed in section 2. In addition; MassHealth is expanding the community outreach grant model to include organizations with existing networks among eligible populations, such as hospitals and social service organizations, to drive enrollment.

If you would like additional information on the activities summarized in this report, please do not hesitate to contact me or my staff.

Sincerely,

A handwritten signature in black ink, appearing to read "JudyAnn Bigby". The signature is fluid and cursive, with the first name "JudyAnn" and last name "Bigby" clearly distinguishable.

JudyAnn Bigby, M.D.

cc: Senator Richard R. Tisei
Representative Bradley H. Jones
Representative Ronald Mariano
Representative Robert S. Hargraves

Chapter 58 Implementation Report Update No. 11

Governor Deval L. Patrick

Lieutenant Governor Timothy P. Murray

Secretary of Health and Human Services
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Section 1: MassHealth Update

The Office of Medicaid reports the following progress on Chapter 58 initiatives:

Insurance Partnership

MassHealth successfully implemented an increase in the income limit for eligibility in the Insurance Partnership from 200% to 300% of the federal poverty level (FPL), on October 1, 2006. This expansion allowed a larger number of low-income Massachusetts residents who work for small employers to participate in the IP program. As of January 2008, there are over 8,256 policies through the Insurance Partnership with close to 18,249 covered lives. More than 6,557 employers participate in the program.

Children's Expansion up to 300% FPL

On July 1, 2006, MassHealth implemented expansion of MassHealth Family Assistance coverage to children in families with income greater than 200%, and up to 300% of the FPL. As of December 2007, there were 57,500 children enrolled in Family Assistance, up from 31,000 in June 2006. More than 18,000 of those children are new members and/or converted Children's Medical Security Plan members enrolled as a result of the income expansion.

MassHealth Essential

Effective July 1, 2006 the enrollment cap for MassHealth Essential was increased from 44,000 to 60,000. This allowed MassHealth to enroll more than 12,000 applicants who were on a waiting list at that time. As of December 2007, Essential enrollment was 57,700.

Wellness Program

Section 54 of Chapter 58 requires that MassHealth collaborate with the Massachusetts Department of Public Health (DPH) to implement a wellness program for MassHealth members. It specifies five clinical domains: diabetes and cancer screening for early detection, stroke education, smoking cessation, and teen pregnancy prevention. The law mandates co-payment and premium reduction for members who meet wellness goals. However, since members do not pay significant copayments or premiums, alternative incentives have been recommended.

The Wellness Program has completed research and data analysis to set a baseline for accurate tracking of MassHealth members' wellness behaviors. This work is essential for effective measurement and evaluation of the success of the Wellness project.

In February 2007 the Wellness Program project management team developed a two-phase implementation process in order to permit the development of a flexible and sustainable incentive program and to ensure that MassHealth

members and providers support and buy-in to the idea of wellness. Phase one focuses on promoting and educating MassHealth members about the concept of wellness and healthy lifestyle activities. This education is coordinated with the MassHealth providers and with support from the Department of Public Health. Phase two of the Wellness Program, the incentive system, is in the planning stage. It will be implemented after proven methods for encouraging healthy behavioral changes among MassHealth members have been determined through a survey of current employer incentive programs. The survey will be accomplished with a formal Request for Information (RFI) to vendors throughout the state.

MassHealth has met and continues to meet as scheduled with the Wellness Program External Advisory Group to discuss outreach and education ideas and incentive options for members. Additionally the Wellness Program management staff has met with MassHealth executives and CMS to discuss federal support for the member incentive system being investigated through the RFI. The final RFI was posted to Comm-pass in early December 2007. Responses to the RFI have been received and are currently being reviewed.

In early April 2007, the Wellness Program distributed of an English and Spanish wellness brochure and an all-provider bulletin to educate providers about the program. In June 2007 the brochure was mailed to over 600,000 MassHealth member households. In September the brochure was added to the PCC plan materials catalog and the MassHealth customer service team has a supply to distribute to providers and members. The MassHealth Wellness Program Manager continues to present at regional MassHealth provider trainings about the Program, with a focus on opportunities to use the brochure to educate new and current MassHealth members. In October 2007 the annual MassHealth Pharmacy Program Information Sessions included a presentation on the Wellness Program and the tobacco cessation benefit. Early in February 2008, MassHealth held the first meeting of the combined outreach and education team.

As previously reported, the copayment/premium reduction requirement in the law in Chapter 58, as originally passed, proved problematic. Most MassHealth members pay no premiums, and those who do generally pay negligible amounts. Consequently, MassHealth and DPH concluded that such an incentive structure would have little impact on member compliance, and therefore recommended changes to the legislation to allow for alternative wellness incentives. The legislature endorsed this approach in the FY 08 budget in line 4000-0700, "...that the executive office may reduce MassHealth premiums or copayments or offer other incentives to encourage enrollees to comply with wellness goals".

Outreach Grants

In the FY08 budget, \$3.5 million was appropriated for the MassHealth, Commonwealth Care and Commonwealth Choice grant project to award grants to community and consumer-focused public and private non-profit organizations for activities directed at reaching and enrolling eligible Commonwealth residents in MassHealth and Connector Authority programs.

The outreach grants help support the overall goal and mission of health care reform – ensuring that all Massachusetts residents have access to and are enrolled in affordable and quality health care programs. Grantees are responsible for educating and assisting with the application processes for potentially eligible residents for MassHealth, Commonwealth Care, Commonwealth Choice and other health programs such as QSHIP, the Medical Security Plan and employer sponsored insurance.

During planning stages of this project, MassHealth in consultation with the Connector Authority, concluded that a two model approach would yield more efficient and effective outreach and enrollment. The first model has allotted funding for “on the ground” direct service outreach and enrollment efforts. These organizations are responsible for one-on-one education and application assistance. The second model will allot funding for community and consumer-focused public and private nonprofit organizations to serve as lead organizations to a network of organizations working to reach and enroll potentially eligible people in state-subsidized and non-subsidized health insurance programs. The lead organizations will be responsible for establishing or expanding its network of organizations, and for ensuring coordination and collaboration of outreach and enrollment efforts among the participating network organizations. Examples of participating network organizations may include typical health care enrollment sites such as hospitals and community health centers, enrollment assistance organizations, and social service organizations. EOHHS, through the RFR, has encouraged the inclusion of organizations not commonly or exclusively used for health care outreach efforts, such as local community colleges/universities, local business associations, and other civic organizations. This model has been developed in order to avoid duplication and overlap of services taking place out in the community.

Forty-five (45) community-based organizations were awarded funds in November 2007 for the direct service grantee model. These grantees have quickly implemented this program, performing outreach and enrollment activities in their regions. All 45 grant organizations submitted monthly grantee progress reports in January for December activities. As of December 2007, over 6,700 individuals were assisted with the application process, and more than 6,500 newly eligible individuals have been approved for benefits.

The network coordinating grant procurement is in process. Recommendations have been presented to senior executive staff for final sign-off. EOHHS will announce grants in February 2008. The network grant activities will conduct this work throughout calendar year 2008.

MassHealth has hired a Director for the Health Care Reform Outreach and Education unit, as required in line item 4000-0300 of the FY08 budget, to coordinate statewide activities in marketing, outreach, and dissemination of educational materials related to Health Care Reform and to collaborate with the executive office of administration and finance, the department of revenue, the division of insurance, and the Commonwealth Health Insurance Connector Authority to develop common strategies and guidelines for providing informational support and assistance to consumers, employers, and businesses.

Section 2: Connector Authority Update

The Connector continues to make significant progress in implementing many of the important initiatives contained in the landmark health care reform law.

Commonwealth Care

As of January 1st, 2008, 168,924 people have enrolled in Commonwealth Care; nearly 25%, or 42,114, are responsible for making monthly premium payments.

There are a number of programmatic activities that the Commonwealth Care team has focused on since the last reporting period. Planning has begun around the program changes for July 1st. A critical element of this work will be communicating any changes to members in advance of the next open enrollment period, which is currently being planned for April 1st through May 15th.

All of the call center customer service representatives are being retrained over the next three months. This process will ensure that the many program changes that have been implemented over the last year are fully communicated to call representatives.

Finally, the Customer Services/Premium Billing RFR has been released.

Commonwealth Choice

As of January 1st, 2008, 15,938 individuals have obtained coverage through Commonwealth Choice. This figure includes 12,420 subscribers and 3,518 dependents. Commonwealth Choice Voluntary Plan subscribers account for 764 of the total enrollments, a 20% increase from December.

The Commonwealth Choice team is working on the design and development of the Contributory Plan for sale to small employer groups with coverage effective dates of July 1, 2008.

Website

Following the peak in traffic that occurred in mid-November, visit volume has decreased from a high of nearly 49,000 visits per week to normal numbers, averaging about 16,000 visits per week.

Website planning activities are currently focused on a number of initiatives. In addition to working closely with the Commonwealth Choice team in the design and development of the Contributory Plan, the web team is determining the effort required to allow existing customers to renew or shop for an alternative prior to the coverage end date of their existing plan. The team is also assessing the IT resources required to display the new Commonwealth Choice plans to be procured and offered by July 1, 2008. Finally, the team is working with the Small Business Service Bureau to roll out e-pay for existing customers and determine

the implementation of recommendations to streamline the Voluntary Plan enrollment process.

Additional updates

In close conjunction with the Department of Revenue, final planning for the full-scale implementation of the mandate appeals process for tax year 2007 is underway.

On the marketing and outreach front, the Connector has continued to hold *Connect to Health* events at locations across the Commonwealth. These events are intended to allow individuals and businesses to learn about insurance options, obtain guidance on how the health care reform law works and apply for coverage. Most recently, simultaneous events were held at multiple locations in two areas: the Merrimack Valley and South Shore/Metro Boston South. Planning for future *Connect to Health* events is underway.

Section 3: Individual Mandate Preparations

The Department of Revenue (DOR) reports the following progress on Chapter 58 initiatives:

2008 Penalties:

On December 31, 2007, DOR issued draft guidelines on tax penalties for not having health insurance in 2008, Draft Technical Information Release 07-18: Individual Mandate Penalties for Tax Year 2008. Penalties will apply only to adults who can afford health insurance, based on separate standards established by the Health Connector on an annual basis and subject to hardship appeals. While the 2007 penalty is the loss of the personal exemption worth \$219 on an individual's state tax return, the 2008 penalties will be based on one-half the lowest cost plans available through the Connector as of January 1, 2008. Under the draft guidelines, the penalties will range from zero to \$912 for an entire year without coverage. More information on the 2008 penalties is available on DOR's website at: www.mass.gov/dor/hcinfo.

Emergency and Proposed Regulations:

On December 31, 2007, DOR also released emergency and proposed regulations on the individual mandate, 830 CMR 111M.2.1: Health Insurance Individual Mandate, Personal Income Tax Return Requirements. A public hearing on the proposed regulations was held on February 4, 2008. The proposed regulation explains the various aspects of the health insurance individual mandate, including the need for taxpayers to declare health insurance coverage on their Massachusetts income tax return, exceptions to the mandate, calculation of any applicable penalties, employer reporting responsibilities under G.L. c. 62C, § 8B, and appeal rights of taxpayers in connection with the penalty under G.L. c. 111M, § 2. Copies of the regulations are available on DOR's website.

MA 1099-HC (for health care)

To date, DOR has received roughly 90 MA 1099-HC electronic reports from a combination of insurance carriers, employers and third party administrators. On January 31, 2008, DOR released Technical Information Release 08-1: Extension Relating to Electronic Filing with the Department of Revenue of Health Care Coverage Documentation. This TIR extends the deadline for employers or other entities to file electronic reports with the Department from January 31, 2008 to February 29, 2008. For more information, please visit DOR's website.

Outreach

DOR has been working diligently over the past several months to spread the word about the new health care reform law to taxpayers, employers and tax professionals. In January, DOR launched a video tutorial, which walks taxpayers step by step through completing the Schedule HC, the new tax form that individuals must complete to show proof of coverage. This video is available on

DOR's website, and has been distributed to legislators, advocacy and tax professional organizations via CD. DOR also released an online calculator that guides taxpayers through the affordability worksheets to determine if they could have afforded health insurance.

Section 4: Health Safety Net Trust Fund and Essential Community Provider Trust Fund Grants

Health Safety Net Trust Fund Regulations

The Division of Health Care Finance and Policy implemented the Health Safety Net Trust Fund in October 1, 2007. The regulations can be found on the Division's website, www.mass.gov.dhcfp, under regulations, 114.6 CMR 13.00. They address eligibility criteria for reimbursable services, the scope of health services eligible for reimbursement from the fund, the standards for medical hardship, the standards for reasonable efforts to collect payments for the cost of emergency care and the conditions and methods by which hospitals and Community Health Centers are paid by the fund. In advance of this regulatory proposal, the Division conducted a consultative session on June 19, 2007.

The Division also implemented regulation 114.6 CMR 14:00 Health Safety Net Payments and Funding. This regulation sets out the conditions and methods by which acute hospitals and Community Health Centers can file claims for services and receive payments from the Health Safety Net Trust Fund. The regulation implements the requirements of Chapter 58 to pay hospitals based upon claims using a Medicare based payment method. The regulation also implements the requirement that the Health safety Net trust Fund pay Community Health Centers using the Federally Qualified Health Center visit rate. The regulation can be found on the Division's web site, www.mass.gov.dhcfp under regulations, 114.6 CMR 14.00.

Essential Community Provider Trust Fund

Another responsibility of the Health Safety Net Office under Chapter 58 and as amended by Chapter 118G Section 35 (b)(6) is to administer the Essential Community Provider Trust Fund. The purpose of this fund is to improve and enhance the ability of hospitals and community health centers to serve populations in need more efficiently and effectively including but not limited to the ability to provide community-based care, clinical support, care coordination services, disease management services, primary care services and pharmacy management services. The criteria for selection includes the institution's financial performance; the services they provide for mental health or substance abuse disorders, the chronically ill, elderly, or disabled; and the pace, payer mix, prior years awards, cultural and linguistic challenges, information technology, twenty-four hour emergency services and extreme financial distress.

The Division of Health Care Finance and Policy, working with the Executive Office of Health and Human Services, developed a grant application process and scoring/review system, similar to the process employed last year. This process considered applicants financial and essential characteristics in order to determine grant allocation amounts from the \$28 million dollar fund. A cover letter, grant application and instructions were sent to providers and posted on EOHHS/DHCFP websites on July 13, 2007. Hospital and Community Health

Center applications were due on July 31, 2007. Over 80 hospitals and community health centers have applied and requested over \$108 million in funding.

A supplemental budget appropriation passed by the legislature and approved by the Governor included additional funding of \$9.5 million for the Essential Community Provider Trust Fund, for a total of \$37.5 million.

In October 2007, the EOHHS announced 69 provider grants from the Essential Community Provider Trust Fund. The distribution of grants awards included:

- Twenty-five acute care hospitals for a total of \$26.7 million representing approximately 72% of the funding available. The average grant award was \$1.1 million
- One non-acute care hospital received a \$2 million grant. This represents approximately 5% of the total funding available.
- Forty-three community health centers received a total of \$8.8 million. The average grant award is \$205,000 representing approximately 24% of the funding available.

The Division has contracted with all 69 hospitals and CHCs and has distributed approximately \$29.5 million of the total \$37.5 million in funding as of February 11, 2008. All providers are required to complete a standard report on the use of the funds by February 15, 2008. These reports will be reviewed by the Division and used to determine the timing of any additional payments to providers from the ECPTF.

Section 5: Public Health Implementation

Community Health Workers (CHWs)

Community Health Workers are critical to the ongoing success of Health Care Reform and Section 110 of Chapter 58 requires the Massachusetts Department of Public Health (MDPH) to make an “investigation relative to a) using and funding of community health workers by public and private entities, b) increasing access to health care, particularly Medicaid-funded health and public health services, and c) eliminating health disparities among vulnerable populations.”

The newly formed *Community Health Worker Advisory Council* is chaired by DPH Commissioner John Auerbach and will meet in February and May of 2008. Four work groups have been formed:

1. Survey
2. Research
3. Workforce Training and Certification
4. Finance

The work groups have met or held conference calls weekly. Highlights of recent activities include:

Survey of CHWs in Massachusetts

- Finalized the Survey Instrument to be administered to 600 current and potential employers of community health workers.
- Built the online survey, tested it, and assembled a sampling frame.
- Developed contract with the University of Massachusetts Center for Health Policy and Research to create and administer the online survey and to conduct analyses.
- Distribution of the survey will begin during the second week of February 2008.

Research

- Qualitative research, using focus groups at 6 sites across the state, site visits and/or interviews will assess areas not “discernable” through the survey or the literature review.
- A comprehensive review of national literature on Community Health Worker practice, cost and efficacy as well as the effect of CHWs on health disparities, quality of care and access to health care.
- Continued research about other state models of CHW training, certification, reimbursement, and utilization to identify best practices that can be applied in Massachusetts.

Workforce Training and Certification

- Assess current training needs and training opportunities for CHWs in Massachusetts.

- Investigate CHW certification models in other states, as well as certification models in other comparable professions.

Finance

- Continue to investigate existing funding sources and funding mechanisms for CHWs in Massachusetts and other states, and develop possible funding strategies.

Section 6: Insurance Market Update

Health Access Bureau

Chapter 58 of the Acts of 2006 directs the Division of Insurance to establish a Health Access Bureau within the Division of Insurance to oversee small group and individual health insurance markets, plan affordability and the quality of plan information for consumers. The Division of Insurance has hired an actuary for the Health Access Bureau who will start with the Division on February 11, 2008. A candidate has been selected for the research analyst position and the paperwork in process to offer the position to the candidate. The financial analyst position has been posted and interviewing is in process. To complete some of the duties required by the Health Access Bureau prior to filling the internal positions, the Division of Insurance has contracted with outside actuaries to develop targeted reports.

Minimum Standards and Guidelines

Chapter 58 of the Acts of 2006 directs the Division of Insurance, in consultation with the Connector, to establish and publish minimum standards and guidelines at least annually for each type of health benefit plan provided by insurers and health maintenance organizations doing business in the Commonwealth. The Division of Insurance has provided information to the Connector on common elements in health policies.

On January 15, 2008, the Division of Insurance issued *Bulletin 2008-02 Requirements for Disclosure of Minimum Creditable Coverage*, which provides the language that carriers must include on health policies so that individuals may understand whether or not their policy meets minimum creditable coverage standards.

Dependent Age

Chapter 205 of the Acts of 2007 changed M.G.L. cc. 175, 176A, 176B, 176G to require a broadening of dependent coverage from those dependents claimed on a parent's federal income tax return to persons qualified as dependents under the IRC. On January 15, 2008, the Division of Insurance issued *Bulletin 2008-01 Amendments Created by Chapter 205 of the Acts of 2007 Related to Eligibility as a Dependent in an Insured Health Plan*, to replace the previously issued Bulletin on dependent age.

Section 7: Employer Provisions

Division of Health Care Finance and Policy

Division of Health Care Finance and Policy (DHCFP) reports the following progress on implementation of the requirements imposed on employers by Chapter 58.

Employer Fair Share Contribution

The Division of Health Care Finance and Policy adopted 114.5 CMR 16.00: Employer Fair Share Contribution on September 8, 2006. This regulation governs the determination of whether an employer makes a fair and reasonable premium contribution to the health costs of its employees, as required by Chapter 58. The Division has determined that Section 16.03 (2) (a), "Employee Leasing Companies," requires clarification. Under that section, employee leasing companies will be required to perform the fair share contribution tests separately for each client company. Although the employee leasing company is responsible for collecting and remitting the Fair Share Contribution on behalf of its client companies, the client company is responsible for any Fair Share Contribution liability.

The Division of Unemployment Assistance held a public hearing on its proposed regulations governing the administration and collection of the Employer Fair Share Contribution. The regulations were subsequently adopted.

Employer Surcharge for State-Funded Health Costs

The Division of Health Care Finance and Policy initially adopted Regulation 114.5 CMR 17.00: Employer Surcharge for State Funded Health Costs on December 22, 2006, with an effective date of January 1, 2007. This regulation implemented the provisions of M.G.L. c. 118G, § 18B. Following enactment of Chapter 450 of the Acts of 2006 on January 3, 2007, the Division repealed this regulation. Chapter 450 changed the effective date of M.G.L. c. 118G, § 18B from January 1, 2007 to July 1, 2007.

The Division adopted regulation 114.5 CMR 17.00 on an emergency basis on July 1, 2007. The regulation reflects the amended legislation, clarifying that a "non-providing employer" subject to surcharge is an employer that does not comply with the requirement in M.G.L. c. 151F to offer a Section 125 cafeteria plan in accordance with the rules of the Connector. The effective date of the regulation is consistent with the July 1, 2007 effective date of the Section 125 cafeteria plan requirement implemented by the Connector. The Division conducted a public hearing on the emergency regulation on September 6, 2007 and has subsequently certified the regulation.

Health Insurance Responsibility Disclosure

The Division of Health Care Finance and Policy initially adopted 114.5 CMR 18.00: Health Insurance Responsibility Disclosure as an emergency regulation effective January 1, 2007, but subsequently repealed the regulation. The regulation implemented M.G.L. c. 118G, § 6C, which was previously effective on January 1, 2007. Chapter 450 of the Acts of 2007, which became effective on January 3, 2007, changed the effective date of M.G.L. c. 118G, § 6C from January 1, 2007 to July 1, 2007.

The Division adopted regulation 114.5 CMR 18.00 Health Insurance Responsibility Disclosure on an emergency basis on July 1, 2007. The regulation incorporates the provisions of Chapter 324 which significantly reduce the amount of information the Division is required to collect from employers. In addition, only employees that have declined to enroll in employer sponsored insurance or to participate in a Section 125 cafeteria plan are required to sign an Employee HIRD form. Employers will retain Employee HIRD forms and will submit them upon request by either the Division of Health Care Finance and Policy or the Department of Revenue. The Division has posted a copy of the Employee HIRD on its website at:

http://www.mass.gov/Eeohhs2/docs/dhcfp/g/regs/employee_hird_form.pdf

The Division conducted a public hearing on the emergency regulation on September 5, 2007 and subsequently certified the regulation.

Division of Unemployment Assistance

The Division of Unemployment Assistance at the Executive Office of Workforce and Labor Development reports the following progress on the implementation of the provisions of Chapter 58 affecting employers.

Employer Fair Share Contribution (FSC)

The first year of employer subjectivity to the Fair Share Contribution law ended on September 30, 2007, and the first annual reporting period began on October 1, 2007. As of early February 2008, the majority of employers who received a notice to file from DUA have completed their on-line Fair Share Contribution report (due on Nov. 15, 2007).

Over 54,000 employers have filed as of early February 2008. More than half of the filers had fewer than 11 full-time equivalent (FTE) employees. Of the employers with 11 or more FTE's, the majority met the standard set in DHCFP regulation for making a "fair and reasonable contribution" to their employees' health insurance. A small portion of filers, 689 employers, did not meet the

requirement and have a combined liability of over \$6.26 million, the majority of which is payable in 4 quarterly installments, as allowed by statute.

Of the 11,600 employers required to file who have not completed the report as of early February 2008, over 1600 have initiated the filing through DUA's on-line filing system. DUA will continue to pursue the remaining non-filers by issuing additional delinquency notices and estimated tax assessments, and by utilizing additional tools to promote full compliance to the FSC reporting and/or payment requirements

Section 8: Health Care Quality and Cost Council

Statewide Goals for the Commonwealth

The Council developed draft recommendations in the areas of strategies for addressing Cost Containment, Chronic Disease Prevention and Management, End of Life Care, Patient Safety, Disparities, and Transparency. The Council's recommendations will:

- “identify the steps needed to achieve the goal;
- estimate the cost of implementation;
- project the anticipated short-term or long-term financial savings achievable to the health care industry and the commonwealth, and
- estimate the expected improvements in the health status of health care consumers in the commonwealth.” [MGL c.6A s.16L(a)] and
- “... develop performance measurement benchmarks for its goals and publish such benchmarks annually, after consultation with lead agencies and organizations and the council's advisory committee.” MGL c.6A, s16L(g)

The Council will include these recommendations in its Annual Report to the legislature in the next 60 day period.

Website Development

The Council has taken several steps toward creating a website that will provide comparative cost and quality information about health care services in a user friendly format, as required by M.G.L. c.6A, s.16L.

- Massachusetts health insurance carriers began working with the Council's vendor, the Maine Health Information Center (MHIC) to submit historical health care claims and eligibility data. As of February 4, 2008, 8 health insurance carriers had met the data quality and formatting requirements to begin submitting historical data, and 11 carriers had met the requirements to submit pharmacy data.
- The Council's Communications and Web Design vendor, Solomon McCown, Inc., developed a draft design for the Council's health care quality and cost information website, including the home page design, look and feel, layout and functionality of each page; navigation; and site map.
- The Council issued an RFP for a Web Application Developer to build the web application in accordance with the specifications developed by the Communications vendor.

Section 9: STATUTORY CHANGES TO CHAPTER 58 SINCE ENACTMENT

The Legislature has enacted three “technical amendment” bills since Chapter 58 first became law in 2006. The most recent technical amendment bill enacted was Chapter 205 of the Acts of 2007, which aimed to ensure that health care reform works as intended. It addressed some operational challenges encountered or anticipated by state and independent agencies charged with implementing various aspects of reform, including provisions that:

- Enable the Health Care Quality and Cost Council to protect the confidentiality of health care claims and other data submitted to the Council, while also allowing it to release some data through a carefully controlled process in furtherance of a public purpose (Section 1)
- Expand the membership and clarify the mission of the Health Disparities Council (Section 2)
- Permit information-sharing between state agencies that is vital to effective implementation of health reform (Sections 3, 7 and 8)
- Correct statutory references to the Health Safety Net Office, which was transferred from M.G.L. c. 118E to M.G.L. c. 118G in the FY08 budget (Sections 4, 9, 10, 11, 18, 25)
- Clarify the definition of "dependent" for purposes of existing requirement that insured health plans offering family policies provide coverage to dependents under the age of 26 or for 2 years following the loss of dependent status under the IRS, whichever occurs first. The law also excludes imputed income resulting from this requirement from Massachusetts gross income for state tax purposes (Sections 5, 6, 31-38, 46)
- Clarify that S-CHIP coverage satisfies the individual mandate (Section 12)
- Clarify the operation of the individual mandate and its application to every adult who files "or is required to file" an individual tax return (Section 13-16)
- Clarify that requirements to offer a Section 125 plan (pre-tax health insurance) and complete the Health Insurance Responsibility Disclosure (HIRD) form apply to employers with "11 or more full-time equivalent employees" (conforming statutory language to existing regulations and the statutory "fair share" requirement) (Sections 22, 23 and 30)

- Require the Health Safety Net Office to enter into an ISA with the Office of Medicaid to enhance oversight and improve operations of the Health Safety Net Trust Fund (Section 26)
- Clarify the definition of an employer covered by the "fair share" requirement (Section 27)
- Eliminate requirements for employers to automatically file Section 125 plan documents with the Connector, though the Connector can still secure copies of plan documents on request (Section 30)
- Expand eligibility for Young Adult Plans offered through the Connector to eighteen year-olds (eligibility was previously reserved only for those ages 19-26) (Section 40)
- Create a special commission to investigate and study the role of Connector in providing access to health insurance, including its use of private sector entities (Section 41)
- Extend the deadline for Health Care Quality and Cost Council to post detailed comparative cost and quality information on its website (Section 42)
- Direct the Connector to report on implementation of M.G.L. c. 118H sec. 3(b) (Section 43)

-END-